DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

Chart Number: _____

NEW PATIENT INFORMATION

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

Patient's Name:_____ Sex: ☐ M ☐ F

Date of Birth:_____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Social Security:_____ Driver's License or ID #: _____

Parent/Guardian's name if patient is under 18yrs old: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Email:_____

Primary Care Doctor:_____ Phone:_____

Primary Care Doctor Address: _____

Patient's Employer:_____ Occupation: _____

Pharmacy Name_____ Phone:_____

Pharmacy Address:_____

How did you hear about us?: _____

INSURANCE

Primary Insurance:_____ ID #: _____

Policy Holder: _____ Policy Holder's DOB:_____

Secondary Insurance: _____ ID #:_____

EMERGENCY CONTACT

Name:_____ Relationship to Patient: _____

Address:_____

City:_____ State:_____ Zip Code: _____

Phone:_____ Work Phone: _____

MEDICAL HISTORY **(PLEASE FILL OUT COMPLETELY AND CLEARLY)**

Chart Number: _____

Name of Patient: _____ DOB: _____

Please describe the reason for visiting the office today (***MUST BE FILLED IN***): _____

Current Medications:

_____ _____ _____

_____ _____ _____

_____ _____ _____

Are you allergic to any medications? ☐ Yes ☐ No | If YES please list:

_____

Do you have now or have you ever had the following diseases or conditions:

Dermatological:

Acne	☐ Yes ☐ No
Eczema	☐ Yes ☐ No
Hives	☐ Yes ☐ No
Psoriasis	☐ Yes ☐ No
Other Skin Issues	☐ Yes ☐ No

Mental:

Anxiety	☐ Yes ☐ No
Depression	☐ Yes ☐ No
Psychiatric Care	☐ Yes ☐ No

Respiratory:

Bronchitis	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Chronic Cough	☐ Yes ☐ No

Vascular:

High Blood Pres.	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No
Heart Attack	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No
Irreg. Heart Rate	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Phlebitis	☐ Yes ☐ No

Other Conditions:

Diabetes	☐ Yes ☐ No	Glaucoma	☐Yes ☐ No
Thyroid	☐ Yes ☐ No	Epilepsy, Seizures	☐Yes ☐ No
Kidney	☐ Yes ☐ No	HIV/AIDS	☐Yes ☐ No
Bladder	☐ Yes ☐ No	Incontinence	☐Yes ☐ No
Stomach	☐ Yes ☐ No		
Bowel	☐ Yes ☐ No		
Hepatitis	☐ Yes ☐ No		
Arthritis	☐ Yes ☐ No		
Convulsion	☐ Yes ☐ No		
Fainting	☐ Yes ☐ No		
Joint	☐ Yes ☐ No		
Deformity	☐ Yes ☐ No		

Do you drink alcohol? ☐ Yes ☐ No | If YES, how many per day? _____

Do you take IV drugs? ☐ Yes ☐ No | If YES, which one? _____ How much? _____

Have you ever had dental anesthesia (Novocain)? ☐ Yes ☐ No

Any bad reaction to anesthesia? ☐ Yes ☐ No

Skin:

When exposed to the sun, do you? ☐ Tan ☐ Tan & Burn ☐ Burn

Have you ever had skin cancer? ☐ Yes ☐ No

Has anyone in your family ever had skin cancer? ☐ Yes ☐ No

Do you have any history of skin disease? ☐ Yes ☐ No

If YES, please list: _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

Do you Smoke? ☐ Yes ☐ No | If YES, how much? _____

Do you bleed easily? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No

Do you have artificial joint(s)? ☐ Yes ☐ No

Patient or Guardian Signature _____ Date: _____

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

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Patient Name: _____

FINANCIAL AGREEMENT & AUTHORIZATION FOR TREATMENT

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

PAYMENT POLICY

We take Cash, Checks, Money Orders, Debit Cards, Visa and Mastercard Credit cards. Patients without insurance can receive care at a self-pay rate, which is due in full at the time of service. We require insurance co-payments, deductibles and co- insurance amounts to be paid at the time of service. We have your insurance companies fee schedule and will only charge you the amount allowed by your insurance company.

We will process insurance claims for office procedures or surgery, however, please be aware that you, the patient, are responsible for the bill. Prompt payment of any amounts due after your insurance has paid is necessary to remain a patient of this practice. In addition, any patient who files bankruptcy and lists Dr. Robert A. Norman, DO, MPH, MBA & Associates as a debtor will no longer be seen by this office.

Accounts that are delinquent after 90 days may be subject to collection and all costs involved, including, but not limited to, attorney fees, court costs, and judgment interest, and will be considered patient responsibility. Any legal action will be filed in the Hillsborough County Court system. If your account is sent to collections, you will no longer be seen by this office

I hereby authorize payment of medical benefits to Dr. Robert A. Norman, DO, MPH, MBA & Associates for services furnished to me by my provider. I further agree to pay all co-pays, deductibles, non-covered services or charges considered above usual and customary (non-contracted carriers only) by my insurance company.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dr. Robert A. Norman, DO, MPH, MBA & Associates to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Dr. Robert A. Norman, DO, MPH, MBA & Associates' Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Robert A. Norman, DO, MPH, MBA & Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dr. Robert A. Norman, DO, MPH, MBA & Associates' Privacy Officer at 8002 Gunn Hwy. Tampa, FL 33626.

With this consent, Dr. Robert A. Norman, DO, MPH, MBA & Associates may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls, pertaining to my clinical care, including laboratory results among others. Dr. Robert A. Norman, DO, MPH, MBA & Associates may also mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient information.

I have the right to request that Dr. Robert A. Norman, DO, MPH, MBA & Associates restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Dr. Robert A. Norman, DO, MPH, MBA & Associates' use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dr. Robert A. Norman, DO, MPH, MBA & Associates may decline to provide treatment to me. (Patients under 18 years of age will need a parent or guardian signature authorizing treatment and consenting to financial responsibility.)

Name of Patient or Legal Guardian	Signature of Patient or Legal Guardian	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

Chart Number: _____

Patient Name: _____

HIPAA - PATIENT CONSENT FORM

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations
- The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease The Practice may condition receipt of treatment upon the execution of this Consent.

☐ I give permission for _____ DOB _____
to receive and obtain my medical information. This is effective until I revoke in writing.

☐ I give permission for _____ DOB _____
to receive and obtain my medical information. This is effective until I revoke in writing.

☐ I do not authorization a HIPAA designee

This Consent was signed by:

Patient or Representative's Name	Patient or Representative's Signature	Date
Relationship to Patient	Witness/Practice Representative Signature	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

Chart Number: _____

Patient Name: _____

DOCTOR-PATIENT ARBITRATION AGREEMENT

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

This agreement is made between Robert A. Norman D.O., P.A., their agents, employees or any of the foregoing, referred to herein after as "Doctor" and referred to herein after as the patient. It is the intention of the parties to this agreement to bind not only themselves, but also their heirs, personal representatives, guardians, *children, spouses* or any person deriving their claims or on behalf of *the* patient.

It is understood by the patient that he or she is not required to use Dr. Norman and Associates, nor any of the foregoing referred to us "doctor" for dermatology services and that there are numerous other physicians in the Tampa Bay area who are qualified to perform dermatology services.

For and in consideration of the mutual benefits flowing one to the other, it is understood and agreed that *in the* event of any controversy, dispute or claims which might arise between the doctor and the patient, regardless of whether the dispute concerns the medical care rendered, or payment of surgical or other fees, or any other matter whatsoever, the dispute shall be resolved by arbitration as provided In the Florida Arbitration Code, Chapter 682, Laws of Florida. IT IS UNDERSTOOD THAT THIS ARBITRATION SHALL BE IN LIEU OF AND INSTEAD OF ANY TRIAL BY JUDGE OR JURY. Each party shall choose one arbitrator and the two arbitrators shall choose a third arbitrator. The arbitrators shall be licensed physicians certified by the American Board of Dermatology and actively engaged in the practice of Dermatology in the State of Florida. The panel of arbitrators shall hear and decide the controversy, dispute or claim, and the decision shall be binding on all parties.

It is further understood and agreed by the parties hereto that the arbitration of any controversy, dispute or claim pursuant to this agreement shall be commenced within the time prescribed by the applicable Florida Statue of Limitations. An action pursuant to this agreement shall be deemed to commence upon the receipt of a written claim notifying the Doctor or Patient, whichever the case may be, of the nature of the controversy, dispute or claim, and demanding that the parties proceed with arbitration in accordance with the terms or this agreement.

Patient or Representative's Name	Signature	Date
Doctor or Authorized Representative's Name	Signature	Date
Witness Name	Witness Signature	Date

DR. ROBERT A. NORMAN, DO, MPH, MBA
Dermatology

PATHOLOGY PAYMENT GUIDELINES

(PLEASE FILL OUT COMPLETELY AND CLEARLY)

In order to determine the laboratory that any specimens taken will go to, please ask a front desk receptionist for an updated list of payers and corresponding laboratories. All specimens within Dr. Robert A. Norman's office will be sent to a third-party laboratory and the patient or responsible party will receive a bill from that third-party laboratory.

Self-pay patients will be responsible for any laboratory bills. Pathology is NOT included in the price of the Biopsy.

Patient or Responsible Party's Name _____ Signature _____ Date _____

No Show Fee Policy:

Patients must contact our office during business hours from 9 a.m. to 5 p.m., Monday through Friday, 24 hours in advance, to cancel their appointment. Failure to contact our office will result in a charge to the patient.

The fees are:

New patient visit: $50.00 Follow-up visit: $50.00

The fee must be paid in full before your next appointment can be scheduled.

Patient or Representative's Name _____ Signature _____ Date _____